Member Enrollment/Member Change Form

Anthem BlueCross BlueShield

To be completed by employer

Firm division no.	Health benefit plan	Requested effective date (MM/DD/YYYY)

Section 1. Employee information

Current Anthem contract no., if any	Last name	First name	M.I.

Home street address or P.O. box	City	State	ZIP code

Home phone no.	Work phone no.	Marital status: ☐ Single ☐ Married ☐ Legally separated ☐ Separated ☐ Widowed ☐ Divorced

Email address

Section 2. Enrollment reason

☐ New group (initial enrollment) ☐ Annual enrollment ☐ New hire
☐ COBRA/CGS 38A-538: Reason: _____ Qualifying event date: ____

Section 3. Change status – Please check the reason(s) for change below and indicate date.

Type of change
☐ Name (indicate former name): _____ ☐ Address ☐ Other reason: _____ Date: ____

Section 4. Membership choices

	Individual	Two person	Family
☐ Access Blue New England	☐	☐	☐
☐ Blue Care Plan name: _____	☐	☐	☐
☐ Blue Choice New England	☐	☐	☐
☐ Century Preferred/PPO Plan name: _____	☐	☐	☐
☐ Century Preferred/EPO Plan name: _____	☐	☐	☐
☐ HMO Blue New England	☐	☐	☐
☐ HSA[1] Plan Plan name: Lumenos HDHP with HSA	☐	☐	☐
☐ HRA Plan Plan name: _____	☐	☐	☐
☐ HIA Plan	☐	☐	☐
☐ Dental Plan name: _____	☐	☐	☐
☐ Blue View Vision Plan name: _____	☐	☐	☐
☐ Other Plan name: _____	☐	☐	☐

Are you or any other eligible dependent listed on this form currently confined to a hospital or other health care facility, totally disabled or physically impaired?
☐ Yes ☐ No

Section 5. Employer information

Company name

Are you actively at work? ☐ Yes ☐ No If no, reason: ☐ Sick ☐ Injured ☐ Other: _____	Are you currently claiming Workers' Compensation medical benefits? ☐ Yes ☐ No

Date of full-time hire[2]	Date of part-time hire[2]	Date of rehire[2] (if applicable)	Do you work 30 or more hours per week? ☐ Yes ☐ No Hours: _____

1 Confirm with your employer which HSA custodian was selected.
2 Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

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Section 6. Employee and dependent information – List only family members you wish to add or cancel.

Add	Cancel	Vision	Name(s) of person(s) (Last name, first name, M.I.)	Sex	Date of birth (MM/DD/YYYY)	Full-time student age 19 or over?	Name of recognized institution for full-time students	Primary Care Physician (PCP) name (Refer to provider directory on anthem.com)	Current Patient?
☐	☐	☐	Self Social Security no.[1] (required)	☐ M ☐ F				Name City PCP no.	☐ Yes ☐ No
☐	☐	☐	☐ Legal spouse ☐ Domestic partner Social Security no.[1] (required)	☐ M ☐ F				Name City PCP no.	☐ Yes ☐ No

Children up to age 26 or disabled dependents may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.

☐	☐	☐	Dependent Social Security no.[1] (required)	☐ M ☐ F		☐ Yes ☐ No		Name City PCP no.	☐ Yes ☐ No
☐	☐	☐	Dependent Social Security no.[1] (required)	☐ M ☐ F		☐ Yes ☐ No		Name City PCP no.	☐ Yes ☐ No
☐	☐	☐	Dependent Social Security no.[1] (required)	☐ M ☐ F		☐ Yes ☐ No		Name City PCP no.	☐ Yes ☐ No

Section 7. Prior coverage information – This section must be completed.

Do you or any other member of your family have any other medical, dental, or Anthem Blue Cross and Blue Shield (Anthem) coverage?
☐ Yes ☐ No **If yes, please complete the following.**

	Self	Spouse/Domestic Partner	Dependents 1	2	3
Name of insurance company					
Certificate (policy) no.					
First and last date of coverage					
Reason for termination					

Section 8. Medicare/Medicaid information

Do you or any covered member have Medicare/Medicaid coverage?
☐ Yes ☐ No

Have you or any covered member applied for Medicare/Medicaid disability?
☐ Yes ☐ No

Name(s) of Medicare beneficiaries	Are you actively at work?	Retirement date (MM/DD/YYYY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

Section 9. Employee signature – Required.

For insurance entities, the term "medical loss ratio" refers to the ratio of incurred claims to earned premium for a prior calendar year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2015, Anthem's Medical Loss Ratio for state law purposes was 81.4% for HMO plans and 81.4% for PPO/Indemnity plans. For 2015, Anthem's MLR for federal law purposes was 84.6% for small group plans and 89.9% for large group plans.

I understand that intentionally false and/or intentionally incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my *Subscriber Agreement* or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

W-9 Certification Language: I certify each Social Security number listed on this application is correct.

Employee signature **X**	Print name	Date (MM/DD/YYYY)

1 Anthem is required by the Internal Revenue Service to collect this information.